RETIREE DENTAL ENROLLMENT/CHANGE (FORM-RD)

This form is intended for use ONLY by GIC members without access to a digital device. GIC members with an up-to-date email address on GIC records received a registration email for the **MyGICLink Member Benefits Portal**. MyGICLink allows GIC members to view their benefits throughout the year and update coverage during Annual Enrollment or if experiencing a qualifying event in just a few minutes. Learn more at **mass.gov/mygiclink-member-benefits-portal**. If you haven't received a MyGICLink registration email, please include your email on this form.

REQUIRED

INSURED INFORMATION

Insured Information	GIC-ID (usually Soc. Sec. #) – –	Sex ☐ M ☐ F	Date of Birth / /	Dept. ID # or Agency/Division # /
	Name – Last	First		MI
Address	Street	City	State	Zip
Contact Information	Preferred Phone ( )	Preferred Email		Country *(if not USA)*

Retirement Information	Name of State Agency or Municipality retired from	Do you receive a monthly pension from a public retirement system? ☐ Yes ☐ No	Date of Retirement / /
Survivor Information	Name of Deceased Employee or Retiree	Deceased Employee's/Retiree's Soc. Sec. # - -	Have you remarried? ☐ Yes Date of remarriage___/___/_____ ☐ No

REQUIRED

Select all that apply:

- ☐ New Enrollment (New Eligibility)
- ☐ Adding Dependent(s)
- ☐ Dropping Dependent(s)
- ☐ Address Change
- ☐ Name Change
- ☐ Annual Enrollment

Qualifying Event (Date of Event: ____ / ____ / _____)

- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce/Legal Separation
- ☐ Change in Dependent Eligibility Status
- ☐ Gain of Other Coverage
- ☐ Involuntary Loss of Other Coverage
- ☐ Death of spouse/dependent
- ☐ Spouse's Annual Enrollment

RETIREE DENTAL

Effective Date: / 01 /

Coverage Election (check one) ☐ Individual ☐ Family

Cancel ☐ GIC Retiree Dental Coverage

- If you do not sign up for coverage within 60 days of retirement, you will not be able to enroll until the next annual enrollment period, unless you involuntarily lose dental coverage during the year or have a qualifying status change and apply within 60 days of the event.
- If you sign up for coverage and decide to cancel, you can never rejoin the plan.
- If you have family coverage and switch to an individual plan, your spouse and/or your eligible dependents can never rejoin the plan.

List below all family members, including your spouse, who will be covered under your dental plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. The Group Insurance Commission requires you to provide a copy of a marriage certificate, birth certificate, legal separation, divorce decree, or certificate of appointment as legal guardian for each person you list as a dependent. Do not send original documents because they will not be returned.

SPOUSE/DEPENDENT INFORMATION

For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
☐ Add ☐ Drop					/ /	☐ M ☐ F	
☐ Add ☐ Drop					/ /	☐ M ☐ F	
☐ Add ☐ Drop					/ /	☐ M ☐ F	
☐ Add ☐ Drop					/ /	☐ M ☐ F	
☐ Add ☐ Drop					/ /	☐ M ☐ F	

FORMER SPOUSE INFORMATION If Listed Above

Date of Divorce: / /

Are you remarried? ☐ Yes ☐ No	Date of your remarriage: / /	Has your former spouse remarried? ☐ Yes ☐ No	Date of former spouse's remarriage: / /
Address: Street		City	State / Zip

SIGNATURE REQUIRED

AUTHORIZATION – I have read the instructions above and direct my pension authority to deduct from my pension check the amount required for the coverage I have selected. If premiums are not deducted enrolled members will receive a monthly bill for premiums due. I understand that my coverage elections are binding for the duration of the plan year and that I may only enroll in or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, divorce, death of a dependent, and involuntary loss of other coverage). I understand that the GIC must receive any required documentation within 60 days of the event. **You must notify the GIC of a legal separation, divorce or remarriage of you or your former spouse; coverage for a former spouse ends upon remarriage. Failure to notify the GIC can result in financial liability to you.**

Signature of Applicant:_____ Date: _____

This form may only be signed by the employee/retiree or someone authorized by the GIC to sign on the employee/retiree's behalf.

Form and Document Submission – Incomplete forms and insufficient required documentation may result in no coverage or a delayed effective date.

ONLINE: Visit bit.ly/MyGICLinkOnlineForms to request and submit your enrollment form(s).

MAIL: Mail completed form to the GIC:

Group Insurance Commission
PO Box 556, Randolph, MA 02368.